Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR PETER E GRAYS
1909 CETNRAL DRIVE SUITE 202
BEDFORD TX 76021

Respondent Name
FORT WORTH ISD

Carrier's Austin Representative Box
Box Number 16

MFDR Tracking Number
M4-11-2886-01

MFDR Date Received
APRIL 26, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "certain procedures were not paid correctly pursuant to your R51: THE SURGICAL PROCEDURE FALLS WITHIN THE MEDICARE MUTLIPLE PROCEDURE GUIDELIENS AND HAS BEEN PRICED ACCORDINGLY. It is our position that these procedures meet the guideliens per CMS for an exception to your multiple procedure rule."

Amount in Dispute: $1,238.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2010	CPT Code 49568-59	$418.96	$73.92
	CPT Code 49507-59-LT	$481.31	$84.94
	CPT Code 55520-59-LT	$338.72	$59.77
TOTAL		$1,238.99	$218.63

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the

disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1-Workers compensation state fee schedule adjustment.
   - R51-The surgical procedure falls within the Medicare multiple procedure guidelines and has been priced accordingly.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Is the requestor entitled to additional reimbursement for CPT Code 49568-59?
2. Is the requestor entitled to additional reimbursement for CPT Code 46507-59-LT?
3. Is the requestor entitled to additional reimbursement for CPT Code 55520-59-LT?

Findings

1. According to the submitted explanation of benefits the insurance carrier paid CPT code 49568 based upon reason codes "W1 and R51".

   CPT code 49568 is defined as "Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)."

   The requestor states in the position summary that "It is our position that these procedures meet the guideliens per CMS for an exception to your multiple procedure rule."

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2010 DWC conversion factor for this service is 68.19.

   The Medicare Conversion Factor is 36.8729

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 76104, which is located in Tarrant County.

   The Medicare participating amount for code 49568 in Tarrant County is $266.52.

   CPT code 49568 has a multiple procedure indicator of "0". The "0" indicator means criteria does not apply.

   Using the above formula, the MAR is $492.88.

   The respondent paid $418.96. The difference between the MAR and paid is $73.92; this amount is recommended for additional reimbursement.

2. According to the submitted explanation of benefits the insurance carrier paid CPT code 49507 based upon reason codes "W1 and R51".

CPT code 49507 is defined as “Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated.”

The requestor appended modifier “59 – Distinct Procedural Services” to code 46507.

Modifier 59 is defined as “Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.”

On the disputed date of service, the requestor billed CPT codes 49561, 49507, 49568 and 55520.

The requestor did not support the use of modifier “59” because code 46507 is not integral to another procedure performed on this date, and is a procedure that may be reported with the codes billed.

The requestor states in the position summary that “I understand that during this operative period two hernias were repaired. But by appending modifier 59, I am showing the difference in both procedure codes to reflect in reimbursement at 100% negotiated rate for both procedure codes 49561 and 49507. Where your company has left procedure code 49507 paid at 50% negotiated rate due to your multiple procedure discounts, by appending modifier 59, I am showing that this is procedure has a different incision than the primary procedure 49561. For procedure code 49507 the incision was located in the left lower quadrant groin area where as the incicion for procedure code 49561 was located in the upper umbilical region of the abdomen wall. Therefore, by definition of modifier 59 with seprate incisions from both procedures by appending the modifier 59 both procedures should be paid at 100%.”

A review of the operative report indicaters claimant underwent “Repair of incarcerated ventral hernia, implantation of mesh, repair of incarcerated left inguinal hernia, and removal of cord lipoma.”

The Division finds that CPT code 49507 is not exempt from the multiple procedure rule discounting because this code has a payment indicator of “2.” This rule applies to all procedures performed by the provider during an operative session. Therefore, the MAR for CPT code 49507 is:

The Medicare participating amount for code 49507 in Tarrant County is $612.38.

Using the above formula, the MAR is $566.25.

The respondent paid $481.31. The difference between the MAR and paid is $84.94; this amount is recommended for additional reimbursement.

3. According to the submitted explanation of benefits the insurance carrier paid CPT code 55520 based upon reason codes “W1 and R51”.

   CPT code 55520 is defined as “Excision of lesion of spermatic cord (separate procedure).”

   The requestor appended modifier “59 – Distinct Procedural Services” to code 55520.

   The requestor states “I am appealing full 100% negotiated rate for procedure code 55520 since your company has applied your multiple procedure rules to per reason R51…Per AMA Guidelines, when appending a modifier 59 (distinct procedural service) to CPT code 55520, it is reimbursable when the procedure is performed independently, unrelated, distinct from other procedures, services provided.”

   The requestor did not support the use of modifier “59” because code 55520 is not integral to another procedure performed on this date, and is a procedure that may be reported with the codes billed.

   The Division finds that CPT code 55520 is not exempt from the multiple procedure rule discounting because this code has a payment indicator of “2.” This rule applies to all procedures performed by the provider during an operative session. Therefore, the MAR for CPT code 55520 is:

   The Medicare participating amount for code 55520 in Tarrant County is $430.96.

   Using the above formula, the MAR is $398.49.

   The respondent paid $338.72. The difference between the MAR and paid is $59.77; this amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 218.63.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $218.63 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		08/15/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.